

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005727</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/13/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>NOVAMED SURGERY CENTER OF MERRILLVILLE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>8514 BROADWAY AVE MERRILLVILLE, IN 46410</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005727</p> <p>Survey Date: 06/12 &amp; 6/13/2012</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Karilyn Tretter, RN Public Health Nurse Surveyor</p> <p>Novamed Surgery Center of Merrillville is in compliance with 410 IAC 15.2, Ambulatory Surgery Center Licensure Rules.</p> <p>QA: cloughlin 06/27/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1